

HEALTH POLICY COMMISSION

958 CMR 4.000 Health Insurance Open Enrollment Waivers

4.001: Scope and Purpose

958 CMR 4.000 establishes the requirements for requests by consumers who wish to enroll in a nongroup health plan outside of the open enrollment periods established by M.G.L. c. 176J. 958 CMR 4.000 applies to all carriers subject to the requirements of M.G.L. c. 176J.

4.002: Effective Date

958 CMR 4.00 shall be effective on April 20, 2013.

4.003: Authority

958 CMR 4.000 is promulgated pursuant to M.G.L. c. 6D § 16 and M.G.L. c. 176J.

4.020: Definitions:

As used in 958 CMR 4.000 the following words shall have the following meanings:

Carrier, an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a non-profit medical service corporation organized under M.G.L. c. 176B; or a health maintenance organization organized under M.G.L. c. 176G. For the purposes of 958 CMR 4.000, “carrier” also means an agent of a carrier that reviews or processes enrollment applications, including but not limited to, the Connector.

Connector, the Commonwealth Health Insurance Connector Authority established by M.G.L. c. 176Q, § 2(a).

Creditable Coverage, coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days:

- (a) a group health plan;
- (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under M.G.L. c. 15A, § 18 or a qualifying student health program of another state;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (e) 10 U.S.C. 55;
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a state health benefits risk pool;
- (h) a health plan offered under 5 U.S.C. 89;
- (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191;

- (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e);
- (k) coverage for young adults as offered under M.G.L. c. 176J, § 10 ; or
- (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996.

“Creditable Coverage” is used as a criterion for eligibility for enrollment outside of the open enrollment period as defined in M.G.L. c. 176J and 211 CMR 66.00. It is different from “minimum creditable coverage” as defined by the Connector pursuant to 956 CMR 5.00.

Eligible Individual, an individual who is a resident of Massachusetts and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage, and his or her eligible dependents.

Enrollment Waiver, permission granted to an eligible individual by the Office of Patient Protection to enable such individual to enroll in a nongroup health benefit plan outside of the open enrollment period.

Health Benefit Plan or Health Plan, a policy, contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Intentionally Forgo Enrollment, an individual turned down the opportunity to enroll in or failed to apply for a health benefit plan or any plan offering creditable coverage, for any reason, when the individual was eligible for enrollment.

Minimum Creditable Coverage, the lowest threshold health benefit plan as determined by the Connector pursuant to 956 CMR 5.00 that a resident must purchase in order to satisfy the legal requirement to avoid paying a penalty to the Department of Revenue pursuant to M.G.L. c. 111M, §2. “Minimum creditable coverage” is different from “creditable coverage.”

Nongroup Health Plan, a health benefit plan offered pursuant to M.G.L. c. 176J to an eligible individual who is not a self-employed person.

Office of Patient Protection, the office within the Health Policy Commission established by M.G.L. c.6D, § 16.

Open Enrollment or Open Enrollment Period, the mandatory period established by M.G.L. c. 176J, § 4(a)(3). For the purposes of 958 CMR 4.000, “open enrollment” also means the period of time prior to December 1, 2010 during which individuals could enroll in a nongroup health plan at any time.

Resident, a natural person living in Massachusetts, but the confinement of person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident.

4.030: Eligibility for Enrollment Waivers

(1) An eligible individual may apply for an enrollment waiver within 30 calendar days of receipt of notice by a carrier in accordance with regulatory guidance issued by the Division of Insurance that such individual is not eligible to enroll in a health benefit plan outside of open enrollment pursuant to 211 CMR 66.00.

(2) The following individuals are not eligible to apply for an enrollment waiver:

(a) A person who does not meet the definition of “eligible individual” set forth in 958 CMR 4.020.

(b) An individual who is currently enrolled in a nongroup health plan issued pursuant to M.G.L. c. 176J.

(c) An individual who is currently enrolled in a health plan that provides minimum creditable coverage, including but not limited to a group health plan.

(d) An individual who voluntarily terminated enrollment in a nongroup health benefit plan during or since the previous open enrollment period. For the purposes of 958 CMR 4.030(c), “voluntary termination” includes but is not limited to cancellation by a carrier for failure to pay a premium.

(e) An individual who has not first applied to a carrier for enrollment in a health plan and been notified that he or she is not eligible to enroll outside of the open enrollment period.

(3) The Office of Patient Protection is not required to review any request for an enrollment waiver that is received within 30 days of the next open enrollment period.

4.040: Procedure for Submission of Request for Enrollment Waiver

(1) An eligible person shall submit a request for an enrollment waiver on a form specified by the Office of Patient Protection and shall include a copy of the notice from the carrier that denied enrollment to the eligible person.

(2) The Office of Patient Protection shall not charge a fee to any person who requests an enrollment waiver.

4.050: Review of Applications for Enrollment Waivers

(1) The review of enrollment waiver requests is not an adjudicatory proceeding. The Office of Patient Protection shall not be required to conduct a hearing or hold a face-to-face meeting with any applicant.

(2) The Office of Patient Protection may grant an enrollment waiver to an eligible individual who certifies, under penalty of perjury, that such individual did not intentionally forgo enrollment into coverage that is at least actuarially equivalent to minimum creditable coverage and for which the individual is or was eligible during a period of open enrollment.

(3) The Office of Patient Protection may use the following criteria in determining whether to grant an enrollment waiver to an eligible individual.

(a) Evidence of extenuating circumstances that prevented an individual from enrolling in a health benefit plan during the previous open enrollment period, including but not limited to lack of accessibility to minimum creditable coverage;

(b) The similarity of the circumstances to the qualifying events set forth in regulatory guidance issued by the Division of Insurance that permit an individual to enroll in a nongroup health benefit plan outside of the open enrollment period. The Office of Patient Protection may confer with the Division of Insurance in order to make such determination.

(c) The credibility of the evidence presented in the enrollment waiver request.

(4) The Office of Patient Protection may not use the applicant's current health status as grounds for approval or disapproval of an enrollment waiver request.

(5) The Office of Patient Protection shall notify an applicant of its decision in writing within 30 calendar days of receipt of the enrollment waiver request.

4.060: Effect of Decision on a Request for an Enrollment Waiver

(1) The applicant for the request for the enrollment waiver is responsible for notifying the carrier that issued the denial notice of an approval of an enrollment waiver request by the Office of Patient Protection within 30 calendar days of the receipt of the approval.

(2) The carrier shall enroll the eligible individual in accordance with regulatory guidance issued by the Division of Insurance.

(3) An applicant whose request for an enrollment waiver is denied must wait until the next open enrollment period to apply to a carrier for enrollment in a nongroup health benefit plan.

4.070: Reporting to Office of Patient Protection

Each carrier shall provide to the Office of Patient Protection no later than March 15, 2011 and July 1 of subsequent years, the following information to assist the Office of Patient Protection in resolving enrollment waiver requests.

(1) Each carrier shall provide the name, telephone number and e-mail address of the person or persons within its organization who will serve as the general contact for the Office of Patient Protection for enrollment waivers.

(2) Each carrier shall provide the name, telephone number and e-mail address of the person or persons who have the authority to approve enrollment applications.

(3) Each carrier shall provide the name, telephone number and e-mail address of the person or persons to whom the Office of Patient Protection can direct a specific caller with a particular enrollment problem. This information shall include the name and contact information for a specific individual or individuals and shall not be a general customer service number.

(4) If any of this contact information changes, the carrier shall provide the new information in writing to the Office of Patient Protection within ten business days following the change.

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REGULATORY AUTHORITY: 958 CMR 4.000: M.G.L. c. 6D § 16.